MDR Tracking Number: M5-04-3721-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 06-28-04.

The IRO reviewed special reports, therapeutic exercises, office visits, work related/medical disability exam, ultrasound therapy, individual psychotherapy rendered from 09-23-03 through 02-03-04 that were denied based upon "U" and "V".

The IRO determined that the ultrasound therapy **was not** medically necessary. The IRO determined that special reports, therapeutic exercises, office visits, work related/medical disability exam and individual psychotherapy **were** medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-18-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The carrier denied CPT code **99080-73** dates of service 10-31-03, 11-24-03, 12-16-03, 01-27-04 and 02-03-04 with a V for unnecessary medical treatment based on a peer review. The TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **$75.00** ($15.00 X 6 DOS).

CPT code **97110** for dates of service 07-03-03 through 07-29-03 (10 DOS) denied with a "F" denial code (fee guideline MAR reduction). Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202(b); plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 09-23-03 through 02-03-04 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 15th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

AMENDED REPORT

08/13/2004

David Martinez
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-04-3721-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ was injured on ___ while working as a Social Studies teacher for the San Antonio ISD. She measures 5'3" and weighs 160 lbs. She reportedly struck her desk with her knee in external rotation and her foot planted. Her previous history is positive for right knee surgery in 1998 due to a non-related injury. The patient presented to the office of Dr. B, DC on 10/22/02. She presented with a pain scale of 4-5/10. Notes from the early phases of treatment were not provided by the requestor or the respondent. The patient underwent active and passive therapies with Dr. B. A RME exam by Dr. P, MD indicated that surgery was necessary. Eventually a right knee arthroscopic procedure was performed on 9/10/03 by Dr. W. On 9/29/03 the patient was authorized by the surgeon for beginning participation in an active therapy program with ___, OTR. On 9/17/03 Dr. C, MD opined that no chiropractic care was necessary. Dr. K, DO, designated doctor, stated on 10/31/03 that she was not at MMI. Dr. E, DD opined on 3/2/04 that she was not at MMI and needed an unloader brace. An FCE was performed on 4/30/04 then the patient was released to work on 5/4/04 with restrictions.

DISPUTED SERVICES

The disputed services included special reports (99080), therapeutic exercises, office visits (99213), 99455-VR, ultrasound, individual psychotherapy (90806) as denied by the carrier with V & U codes from 9/23/03 through 2/3/04. The services of 7/3/03 through 7/29/03 are fee disputes.

DECISION

The reviewer agrees with the previous adverse determination regarding the following services: 97035 (all dates of service).

The reviewer disagrees with the previous adverse determination regarding all remaining services.

BASIS FOR THE DECISION

The reviewer indicates that there is no evidence of the necessity for the Ultrasound treatments after one month of treatment prior to the dates in question. Regarding the medical necessity of therapeutic exercises it is clear via the records that the patient was improving in both functional methods and pain related values with the treatment being provided. Generally accepted rehabilitation protocols indicate six to eight weeks of knee rehabilitation as being indicated; however, this patient had a pre-existing right knee condition from the 1998 injury. According to the current scientific literature this complicating factor leads to up to a two times increase in the time required for an injury to be treated. Utilizing the eight week normal treatment period times two this leads to a maximum treatment range of 1/29/03. According to the Medical Disability Advisor, the normal non-complicated rehabilitation program is from six to twelve weeks. Complicating factors include obesity, osteoarthritis and previous knee injury. The patient qualifies for two of these three complicating factors according to the records received. Regarding the 99080 code on date of service 9/23/03, this appears to be copies of records sent to a designated doctor from the treating provider. TWCC rule states that this should be paid at a rate of fifty cents per page. This would be a reasonable and necessary charge per TWCC Rule.

References:

1. Arthroscopic surgery. 25 Oct. 2000
2. Reed, P. Medical Disability Advisor, 80.6 Mensicectomy and Meniscus Repair, 2001

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,